



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, <http://healthplan.memorialhermann.org/brokers/resource-center/> or call 855-645-8448. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at <https://www.memorialhermann.org>, <https://www.healthcare.gov/sbc-glossary/> or call 855-645-8448 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|---|
| What is the overall deductible ? | Participating Providers - \$6,850 person / \$13,700 family. Non-Participating Providers - None. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible . |
| Are there services covered before you meet your deductible ? | Yes. Preventive care services are covered before you meet your deductible . Does not apply to penalties, Generic, Preferred brand or Non-Preferred brand prescription drugs . | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | No. | You don't have to meet deductibles for specific services |
| What is the out-of-pocket limit for this plan ? | Participating Providers - \$7,350 person / \$14,700 family; Pediatric Dental - \$350 person / \$700 family. Non-Participating Providers – None. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit ? | Copayments for certain services, premiums , balance-billing charges, penalties for failure to obtain prior authorization for services and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit . |
| Will you pay less if you use a network provider ? | Yes. See http://healthplan.memorialhermann.org/brokers/find-a/?searchfor=doctors or call 855-645-8448 for a list of Participating Providers . | This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a referral to see a specialist ? | No. | You can see the specialist you choose without a referral . |



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|---|--|--|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$40 copay /visit; deductible does not apply | Not covered | None. |
| | Specialist visit | \$70 copay /visit; deductible does not apply | Not covered | None. |
| | Preventive care/screening/immunizations | No charge; deductible does not apply | Not covered | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | Lab – No charge/visit X-ray – No charge/visit | Not covered | Deductible applies first for Lab, X-ray & Imaging; Prior Authorization required for Genetic Testing; Non-compliance may result in a penalty. Prior authorization required on all Imaging. |
| | Imaging (CT/PET scans, MRIs) | No charge/visit | Not covered | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://ctr.benefits.catamaranrx.com/rxpublic/portals/memberMain?custom_er=CTRHX or by calling 1-877-633-4461 | Generic drugs | Retail Preferred: \$4 copay/prescription ; Retail Non-Preferred: \$10 copay/prescription Mail Order: \$10 copay/prescription . Deductible does not apply. | Not covered | Lower cost applies at Preferred Participating Pharmacies. Retail covers 30-day supply and mail order covers 90-day supply. Annual Participating Provider Deductible applies to Preferred Brand and Non-Preferred brand prescription drugs . Participating Provider prescription drug copayments/coinsurance apply to the Annual Participating Provider Maximum Out-of-Pocket . Member responsible for paying applicable copay , allowable claim amount, or the contracted rate of the prescription, if less than the established copay . Prior Authorization required for some Drugs. Non-compliance may result in a penalty. |
| | Preferred Brand drugs | Retail Preferred: \$160 copay/prescription ; Retail Non-Preferred: \$170 copay/prescription Mail Order: \$400 copay/prescription | Not covered | |
| | Non-Preferred Brand drugs | Retail Preferred: \$250 copay/prescription ; Retail Non-Preferred: \$260 copay/prescription Mail Order: \$625 copay/prescription | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|---|--|---|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| | Specialty drugs* | 45%/prescription | Not covered | *30-day supply only; 90-day Mail Order not covered. Deductible applies first; Annual Participating Provider Deductible applies to ALL Specialty Drugs. Prior Authorization required for some Specialty drugs . |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge | Not covered | Deductible applies first; Prior Authorization is required. Non-compliance may result in a penalty. |
| | Physician/surgeon fees | No charge | Not covered | Deductible applies first; Prior Authorization is required. Non-compliance may result in a penalty. |
| If you need immediate medical attention | Emergency room care | No charge/visit | No charge/visit | Deductible applies first. |
| | Emergency medical transportation | No charge/trip | No charge/trip | Deductible applies first. |
| | Urgent care | \$70 copay /visit; deductible does not apply | Not covered | None. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge | Not covered | Deductible applies first; Prior Authorization is required. Non-compliance may result in a penalty. |
| | Physician/surgeon fees | No charge | Not covered | Deductible applies first. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Professional Office Visit - \$40 copay /visit, deductible does not apply. Outpatient services - No charge/visit | Not covered | Deductible applies first for Outpatient Services; Prior Authorization required for Outpatient Services; Non-compliance may result in a penalty. |
| | Inpatient services | No charge | Not covered | Deductible applies first; Prior Authorization is required. Non-compliance may result in a penalty. |
| If you are pregnant | Office visits | No charge | Not covered | Deductible applies first; Prior Authorization is required. Non-compliance may result in a penalty. |
| | Childbirth/delivery professional services | No charge | Not covered | Cost sharing does not apply for preventive services . |
| | Childbirth/delivery facility services | No charge | Not covered | Depending on the type of services, a copayment , coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| If you need help recovering or have | Home health care | No charge/visit | Not covered | Deductible applies first; Limited to 60 visits/year. Prior Authorization required. Non-compliance may |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|---|--|--|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| other special health needs | | | | result in a penalty. |
| | Rehabilitation services | No charge | Not covered | Deductible applies first. Physical Therapy/ Occupational Therapy and Chiropractic: Limited to 35 visits/year/service; and 1 visit per day, (Limitation does not apply to services related to autism spectrum disorder or the treatment of developmental delay). Prior Authorization required for Inpatient & ABA in Cognitive Therapy. Non-compliance may result in a penalty. |
| | Habilitation services | No charge | Not covered | Deductible applies first; Limited to 100 days/year. Prior Authorization is required. Non-compliance may result in a penalty. |
| | Skilled nursing care | No charge | Not covered | Deductible applies first; Limited to Plan Requirements; Prior Authorization Required. Non-compliance may result in a penalty. |
| | Durable medical equipment | No charge | Not covered | Deductible applies first; Prior Authorization required. Non-compliance may result in a penalty. |
| | Hospice services | No charge | Not covered | Deductible applies first; Prior Authorization required. Non-compliance may result in a penalty. |
| If your child needs dental or eye care | Children's eye exam | Primary Care Physician - \$40 copay /visit; All other Providers - \$70 copay /visit; deductible does not apply. | Not covered | One exam/year for children ages 0-19. |
| | Children's glasses | No charge | Not covered | Deductible applies first; Limited to 1 pair of glasses or contact lenses/year ages 0-19; subject to plan limitations. |
| | Children's dental check-up | Class A-No charge; deductible does not apply. Class B, C, D & General Pediatric Dental-50% | Not covered | Participating Provider Deductible & Maximum out-of-pocket amount applies to Class B, C, D, General Pediatric Dental ages 0-19. Prior Authorization required for benefits other than Diagnostic or Preventive Services ages 0-19. Non-compliance may result in a penalty. Subject to Plan Exclusions. |

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Acupuncture
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Bariatric Surgery (Prior Authorization required)
- Chiropractic care (35 visits per year)
- Cosmetic surgery (reconstructive surgery for birth defects, injuries, tumors or infection)
- Hearing aids (1 pair every 36 months)
- Routine eye care (Adult) (1 exam per year)
- Routine foot care (for an illness such as diabetes or a circulatory disorder of the lower extremities)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Memorial Hermann Health Plan Customer Service at 855-645-8448 or <http://healthplan.memorialhermann.org>; Texas Department of Insurance at 1-800-252-3439 or <http://www.tdi.texas.gov>; for group health coverage subject to ERISA, U.S. Department of Labor Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>. Church plans are not covered by the Federal COBRA continuation coverage rules. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: For group health coverage subject to ERISA, U.S. Department of Labor Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>; or Memorial Hermann Health Plan Customer Service at 855-645-8448 or <http://healthplan.memorialhermann.org>.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

-----*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*-----

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$6,850
- [Specialist copayment](#) \$70
- Hospital (facility) [coinsurance](#) 0%
- Other [copayment](#) \$70

This EXAMPLE event includes services like:

- Specialist office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (*ultrasounds and blood work*)
- Specialist visit (*anesthesia*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,800 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$6,850 |
| Copayments | \$100 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$7,010 |

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$6,850
- [Specialist copayment](#) \$70
- Hospital (facility) [coinsurance](#) 0%
- Other [copayment](#) \$70

This EXAMPLE event includes services like:

- Primary care physician office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Durable medical equipment (*glucose meter*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$7,400 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles* | \$3,400 |
| Copayments | \$2,700 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Joe would pay is | \$6,160 |

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$6,850
- [Specialist copayment](#) \$70
- Hospital (facility) [coinsurance](#) 0%
- Other [copayment](#) \$70

This EXAMPLE event includes services like:

- Emergency room care (*including medical supplies*)
- Diagnostic test (*x-ray*)
- Durable medical equipment (*crutches*)
- Rehabilitation services (*physical therapy*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$1,900 |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles* | \$1,600 |
| Copayments | \$200 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,800 |

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact Customer Service at: 855-645-8448.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Multi-Language Insert

Multi-Language Interpreter Services

| Spanish | Vietnamese |
|---|---|
| <p>ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-594-0671.</p> | <p>CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-594-0671.</p> |
| Arabic | Japanese |
| <p>ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-594-0671.</p> | <p>注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-594-0671まで、お電話にてご連絡ください。</p> |
| Cantonese Chinese | Korean |
| <p>注意：如果您說廣東話，您可以免費獲得語言援助服務。請致電1-888-594-0671。</p> | <p>주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-594-0671 전화해 주십시오.</p> |
| Mandarin Chinese | Laotian |
| <p>注意：如果您说普通话，您可以免费获得语言援助服务。请致电1-888-594-0671。</p> | <p>ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-888-594-0671.</p> |
| French | Farsi |
| <p>ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-594-0671.</p> | <p>توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با تماس بگیرید 1-888-594-0671.</p> |
| German | Russian |
| <p>ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-594-0671.</p> | <p>ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-594-0671.</p> |
| Gujarati | Tagalog |
| <p>સુચના: જો તમે ગુજરાતી બોલતા હો, તો ન:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-888-594-0671.</p> | <p>PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-594-0671.</p> |
| Hindi | Urdu |
| <p>ध्यान दें: यदि आप ह्दी बोलते हैं तो आपके लऱि मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-594-0671 पर कॉल करें।</p> | <p>خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں 1-888-594-0671</p> |

Memorial Hermann Health Plan, Inc., Memorial Hermann Health Insurance Company and Memorial Hermann Health Solutions, Inc. (collectively "MHHP") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Memorial Hermann Advantage does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

MHHP:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Customer Service at the number below.

If you believe that MHHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator
Memorial Hermann Health Plan
929 Gessner Road, Suite 1500
Houston, TX 77024

By calling the number on the back of your member ID card
Fax 713-338-6487
Email MHHealthAppeals@memorialhermann.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, (1-800-537-7697 TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.